Safer North Tyneside

DOMESTIC HOMICIDE REVIEW

INDEPENDENT REVIEW REPORT INTO THE DEATHS OF SARAH AND JOHN

EXECUTIVE SUMMARY

Tom Wood
November 2016

1) The deaths of Sarah and John

2) The Domestic Homicide Review Process

3) The Perpetrator – Alcohol – Sexuality – Mental Health

4) Conclusions and recommendations

The deaths of Sarah and John
Background Summary

1. Introduction

1.1 This report concerns a Domestic Homicide review into the deaths of Sarah and John who died in their home in North Tyneside in 2014.

The review considers agencies contacts with Sarah and John as well as Mark, their grandson and son respectively who was responsible for their deaths.

The Homicide Incident

1.2 On an evening in 2014 police were called to an area in North Tyneside where members of the public had detained a man, now known to be Mark, after he was seen running among traffic apparently in an effort to self-harm.

1.3 On arrival of police, Mark told them he had killed his grandmother and father and that their bodies lay in their home nearby.

1.4 Within their home police found the **dead** bodies of Sarah, grandmother of Mark and John, the father of Mark. Both Sarah and John had suffered multiple injuries and some mutilation. Various bladed weapons were found at the scene.

1.5 Mark was arrested and subsequently charged with the murder of Sarah and John. At the time of his arrest Mark was seen to be displaying behaviours which indicated the presence of a mental illness. This included; confusion, laughing inappropriately, spitting at people and speaking in a rambling incoherent manner. Later while in custody he was examined by two psychiatrists who after a number of consultations, diagnosed Mark as suffering from a major mental illness in the form of Schizophrenia, attended by hallucinations, paranoia and persecutory delusions. In June 2014 Mark pled guilty to manslaughter on the grounds of diminished responsibility and was ordered to be detained in a secure hospital without limit of time.

Family Background

1.6 **Hard evidence relating to relationships within the family has been difficult to obtain or confirm. One family member has contributed to the review and while helpful could not describe the dynamics of the family in the immediate period leading up to the deaths of Sarah and John.**

Likewise, local agencies had limited contact with the family and held no current information about relationships within the family before the deaths.

This review is therefore based on the limited information available from police, court and medical reports compiled after the deaths. While

Mark's own account is reflected in the medical reports, this review has had no direct access to the perpetrator Mark.

1.7 The family comprising Sarah (deceased), her sons John (deceased) and Tony lived at the same address in North Tyneside since 1974. John, the husband of Sarah and the father of John and Tony died in 1994.

1.8 Sarah (deceased) worked as a mental health nurse until her retirement. Subsequently she suffered ill-health and at the time of her death had a number of chronic health problems including hypertension, osteoporosis and spinal stenosis. Despite her poor health she continued to live independently and there is no evidence to suggest that she lacked the capacity to care for herself.

1.9 Tony (witness) left the family home in the 1970's and though resident in London since, kept regular contact with his family, particularly his mother (Sarah) visiting her in North Tyneside and telephoning her regularly. Sarah also visited Tony in London sometimes in the company of other members of her family.

1.10.1 John (deceased), the eldest son of Sarah worked with his father in the building industry as a young man, then with the local council as a general repair man.

1.10.2 In about 1987, John began a relationship with Joanne (declined to assist) and shortly afterwards they began living together. Subsequently Joanne fell pregnant. Mark was born in 1988 at 33 weeks with a birth weight of 2.5kgs. His development, sitting, standing, walking and speaking were all slightly delayed but within the normal range. He was treated for Asthma and dermatological problems as a child but there is no history of any referral for mental health issues.

1.10.3 While the relationship between John and Joanne was initially stable it soon became tempestuous. Mark describes his mother as a 'bad coper'. There were several separations between John and Joanne when John returned to his parents' home leaving Mark with his mother. Eventually Joanne was unable to **care for** with Mark and he went to live with his father and grandmother (Sarah and John).

1.10.4 Around 1998, Joanne and John separated permanently and John took custody of his 10 year old son Mark. He returned him to his old family home where Sarah assumed the maternal care of Mark (her grandson). From that time the relationship between Joanne and the rest of the family became increasingly fraught and Mark saw his mother infrequently.

1.10.5 Around the same time (1998/99), both Sarah and John's (deceased) health began to decline and it became more difficult for them to care for the teenage Mark. Despite this, throughout his early teens, Mark was cared for and **was** well behaved **at school** though quiet and without many friends.

1.10.6 After completing his schooling with average results but reasonable behaviour and strong interest in artistic subjects, Mark attended an art course at a local college. It is about this time that his family saw a change in Mark's behaviour. They suspected that he was drinking alcohol heavily and perhaps misusing drugs especially Cannabis. Whatever the cause Mark became occasionally aggressive in his attitude towards Sarah and John.

It should be noted that psychiatric examinations of Mark, post arrest, also identify this time as the point where Mark's behaviour/mental health **appears** to deteriorate.

1.10.7 In 2009 Mark moved from the family home to attend a course at the Southbank University, London. He initially moved into the halls of residence but because of odd behaviour (not further described) was moved to a floor of the halls on his own. He was also arrested but not charged following a fire in one of the kitchens in the halls. During this time Mark returned periodically to the family home in North Tyneside. By this time Sarah and John health had deteriorated further and while they were able to care for themselves they were unable to deal with Mark who **reportedly** continued to drink heavily, spend long periods on the family computer and appear reluctant to seek employment or otherwise engage with the outside world.

1.10.8 At the time of their deaths Sarah and John were struggling to cope with Mark. Their health was fragile and while they continued to support him his behaviour, while always apparently non-violent, had become more difficult to live with or control.

1.10.9 A picture emerges of Sarah and John as caring people in deteriorating health doing their best to cope with an increasingly troubled and difficult Mark. While these difficulties may have included confrontations and on at least one occasion aggressive argument, there is no record or suggestion of physical violence let alone the level of violence displayed in the deaths of Sarah and John.

It should be noted that until the time of her death Tony enjoyed a close and regular **telephone** contact with Sarah, his mother. **This witness** is certain that if any violent or incident of serious mental disturbance had taken place, he would have been made aware of it.

2. <u>The Domestic Homicide Review Process</u>

2.1 Agencies in North Tyneside had limited involvement with the family but due to the nature of the incident the case was referred for a Domestic Homicide Review.

2.2 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force in April 2011.

The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide and ways in which local professionals and organisations can work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how they will be acted on, including timescales, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

These reviews are not inquiries into how the victim died, that remains a matter for the judicial system to determine.

2.3 Northumbria Police referred the deaths of Sarah and John to the Chair of North Tyneside Strategic Partnership for the case to be considered for a Domestic Homicide review. The Chair confirmed with the Home Office that this case met the criteria and that a DHR would be undertaken.

2.4 **Domestic Homicide Review Panel**

Following the decision to carry out a review, a DHR Panel was convened and met for the first time on 25 April 2014.

The DHR Panel is tasked with overseeing the process. The panel/IMR chronology writers consisted of the following individuals:

- Dr Stephen Blades, GP Lead for Adult Safeguarding, NHS North Tyneside Clinical Commissioning Group
- Val Short, Assistant Principal, Longbenton Community College
- Heather Carmichael, Northumbria Healthcare NHS Trust
- Joanne Robson, Northumbria Police
- DCI John Douglas, Northumbria Police
- Anna Stabler, Public Health England
- Frances Blackburn, Newcastle Hospital
- Lesley Thirwell, North East Ambulance Service

In addition, Tom Wood was commissioned to independently Chair the Panel and write the overview report. He is currently an independent chair of two Adult and Child Protection Committees in Scotland, and was the Deputy Chief Constable and Director of Operations of a large police force in Scotland. He has also previously acted as both chair and overview report writer in both Serious Case Reviews and Domestic Homicide reviews.

2.5 The agreed period of time subject to review was between 1998 and 2014, the date of death of Sarah and John.

2.6. **Terms of Reference**

2.6.1 When the DHR was commissioned terms of reference were agreed by the commissioning panel as follows:

- **Q – If there was a low level of contact with your agency why was this? Were there any barriers (particularly ethnic origin, culture or language) to either the victims or accused accessing service or support?**
- **Q – Were there indications of the victims being isolated by the perpetrator and could this have prevented them from accessing service?**
- **Q – Were there any other issues relating to this case such as drug or alcohol abuse and if so what support was provided?**
- **Q – Whether the perpetrator had a history of any violent behaviour and if any referrals were made to services in light of this?**
- **Q – Whether any risk assessments had been undertaken previously on the victims or perpetrator and whether these had judged risk appropriately?**
- **Q – Whether the victims were experiencing coercive control on the part of the accused?**
- **Q – Was there any indication of domestic violence or coercive control occurring before the incident and if so did the victims consider this to be control or domestic abuse.**
- **Q – Was there any information held by informal networks?**
- **Q – To what extent did contact and involvement with the victims and/perpetrator result in formal or informal assessment?**
- **Q – Did the victims origin, culture or language impact on services.**
- **Q – What was the Involvement, role and function of MARAC?**

2.7 **Individual Management Review/Chronologies**

Due to the limited involvement with the family Individual Management Reviews were only required for the General Practitioners representative and Northumbria Police.

In addition, chronologies were prepared by:

- Longbenton Community College – attended by Mark
- North Tyneside General Hospital A & E
- Northumbria Healthcare NHS Foundation Trust
- North Tyneside Adult Social Care

At a late stage in the DHR process (November 2014), two confidential psychiatric reports were made available to the Independent Chair/report writer. These reports contained considerable detail not know to the DHR

before that time. Consequently the DHR process was delayed while this new information was considered.

2.8 **Family Involvement**

The family of Sarah, John and Mark were contacted first by police then by the Independent Chair when the purpose and process of the DHR was explained. While Tony, the son of Sarah, brother of John and uncle of Mark was helpful and supportive of the DHR process, Joanne, the ex-wife of John and mother of Mark declined to be involved with the DHR process **despite numerous attempts to contact and engage with her**.

Notwithstanding, both family members were kept informed of the progress of the DHR. **Tony has been made aware of the conclusions and recommendations of this report.**

2.9 **Review Timings**

Due to the difficulties tracing all Mark's medical records and the late access to two psychiatric reports it was not possible to complete the review in the six month time period as set out in the guidance. The Board of North Tyneside Strategic Partnership were continuously updated as to the progress of the review.

3. The Perpetrator

The information in this section has been abstracted from information provided by family members, police and health/psychiatric reports partly based on interviews with the perpetrator.

3.1 The perpetrator in this case is Mark. He was arrested near the scene of the homicides of his father John and his paternal grandmother Sarah. Subsequently he was diagnosed as suffering from Schizophrenia attended by hallucinations, paranoia and persecutory delusions. He pled guilty to manslaughter on the grounds of diminished responsibility. This plea was accepted by the court and Mark was ordered to be detained at a secure mental hospital without limit of time.

3.2 Mark was born in 1988, the only child of John (deceased) and Joanne (declined to assist this process). In his own account, Mark alleges that from an early age his childhood was disrupted by conflict between his mother and father. **His account is uncorroborated but suggests a degree of emotional abuse.**

3.3 Family accounts suggest that Mark lived with his mother and father in North Tyneside until the age of 5 when his father (John) left following **domestic** arguments. For the next 5/6 years Mark was brought up alone by his mother with intermittent visits by his father. During this time Mark recalls often being confined to his room for fear of upsetting his mother. Finally when Mark was

10/12 years old his mother **found** that she was unable to bring him up alone and he was given into the custody of his father (John) returning to live with him and Sarah in the family home.

3.4 At this time there is no suggestion that Mark was badly behaved, aggressive or disturbed. **It is suggested** that the return of Mark to his father was more to do with his mother's inability to cope, rather than issues with Mark's behaviour.

3.5 Mark settled well with his father and grandmother and while relationships with his mother were still fraught his contact with her became infrequent and he **enjoyed** a stable upbringing with his grandmother (Sarah) assuming the main parenting role.

3.6 Mark was reasonably settled at both primary and secondary schools. His school record shows some minor behavioural problems but none that required serious disciplinary measures. He had a small group of friends and did reasonably well academically, gaining several GCSEs and three A levels.

During this time Mark did not display any symptoms of behavioural or emotional disturbance.

3.7 On leaving school Mark continued to live in the family home and though he worked briefly in mundane jobs he failed to settle in an area of employment, finding a "lack of challenge." Later he pursued courses in communications at a local college and Southbank University but never found an area of work that was successful.

3.8 It appears that it was after he left school, when he was about 18 years old that Mark's behaviour changed and became more disturbed. Family accounts indicate that it was at this time he began to drink alcohol heavily and perhaps use drugs, particularly Cannabis. It is in this period that Mark became more assertive and aggressive to his increasingly frail father and grandmother.

3.9 Although the changes in Mark's behaviour were mainly dealt with within the family, the police logs at the time show four calls from John and Sarah reporting drunken and disorderly behaviour by Mark. He was arrested during one of these incidents but released when John and Sarah declined to give statements to police. It is about this time that Tony (his uncle) confronted Mark about his behaviour and this appears to have resolved the situation, there being no further reports of aggression within the family. There was one further call from Sarah to report Mark's abusive behaviour but no further reports of aggression and Mark then appears to have become reclusive, **remaining** in his room and spending long periods of time on the family computer.

3.10 In 2009, Mark left the family home in North Tyneside and moved to London to study film making at Southbank University. As previously noted, he first lived in halls of residence but after odd behaviour **(no further described)** he was allocated a room in a hall of his own. His drinking remained a problem and he

sought treatment for this and depression/low mood on a number of occasions. **By his own account he** also apparently engaged in **a number of casual** homosexual relationships while in London, this being the firs suggestion of issues with his sexuality.

3.11 Despite these issues Mark lived for two years in university halls of residence and while there were obviously concerns, he apparently completed his first year Foundation Course and paid attention to his studies.

3.12 By 2012 Mark's behaviour was again problematic. He was arrested but not charged with fire-raising within a kitchen in his halls of residence and was reported to suffer from poor personal hygiene.

In 2012 Mark moved from halls of residence to share a flat with a friend but this ended in his squatting in the property when the landlord apparently went bankrupt. He briefly found work as a dog walker but found this unsatisfactory and soon gave up.

3.13 Mark returned to the family home in North Tyneside to stay with Sarah and John over Christmas. He spoke of giving assistance to Sarah and John whose health he recognised was failing.

In the event he stayed beyond the Christmas holidays until the date of Sarah and John's death.

3.14 **Alcohol and Drugs – Sexuality – Mental Health – Schizophrenia**

3.14.1 **Alcohol and Drugs**

As previously indicated Mark began drinking heavily from the age of 18 years. By his own account he drank large amounts of alcohol intermittently but also reported periods of abstinence. It is recorded that on several occasions he sought treatment but such treatment was never successfully carried through due to the intermittent nature of his drinking and his failure to attend for treatment.

3.14.2 While his family believed that Mark was a heavy user of Cannabis and/or Cocaine during his teenage years, the extent of his drug use is unclear. Mark has himself admitted to experimenting with Cannabis and other recreational drugs but details are imprecise.

3.14.3 There can be no doubt as to the serious impact of alcohol on Mark's behaviour. His aggressive behaviour is recorded as starting when he began drinking heavily. Likewise all the critical incidents that are recorded, including the killing of Sarah and John are associated with alcohol.

While it is impossible to judge what bearing Mark's substance abuse had on his eventual conduct, his alcohol abuse certainly played a key role in his behaviour and the homicide of Sarah and John.

3.15 **Sexuality**

3.15.1 Although apparently unknown to his family Mark became aware of his **homosexuality** from an early age. By his own account this led to difficulties in relationships and a number of unsatisfactory encounters, some involving violence. During psychiatric assessment (post arrest) he spoke of watching extreme pornography and violent action films, sometimes repeatedly. He also spoke of having violent thoughts while engaging in sexual acts.

None of this information was known to agencies prior to the murder of John and Sarah.

3.16 **Mental Health**

3.16.1 Although concerns about Mark's mental health first came to attention in 2009 they were considered minor and that he was no risk to himself or others. When examined by a psychiatrist in 2011 there was no evidence of depressive illness or psychotic symptoms.

3.16.2 At the time of his arrest, however, Mark displayed signs of a serious mental disturbance, including paranoia, hearing voices, confusion and hallucinations. Following extensive psychiatric examinations while in custody Mark was diagnosed as suffering from a major mental illness in the form of Schizophrenia. Symptoms of Schizophrenia include; delusions, hallucinations and disorganised speech all of which were displayed by Mark, post arrest.

3.16.3 In making their diagnosis, psychiatrists could not determine when Mark's mental illness started, his chaotic lifestyle/alcohol abuse making this impossible.

3.16.4 What is certain is that at no point prior to the murder of Sarah and John was Mark's mental health or behaviour recorded by family or agencies as dangerous to himself or others.

4. Conclusion and Recommendations

4.1 It seems impossible that a crime of the gravity and extreme violence as the killing of Sarah and John should happen, spontaneously, without warnings or indications to family, friends or agencies in contact with the family. Yet in the case of the this family, all facts known to the review indicate that is exactly what happened.

Although close to the family and in regular contact with them, the only surviving close family member had no indication of violence or risk.

Likewise, agencies who had minimal contact with the family recorded no reports of violence or risk.

The senior psychiatrist who examined Mark (post arrest) is of the view that it may well be that Mark's sporadic heavy alcohol use and withdrawal contributed to his failing mental health and while there is some uncertainty about his Cannabis/drug use, this too may have contributed to his condition.

Notwithstanding, the psychiatrist was of the view that given the level of contact in this case no agency was in a position to predict the deterioration in Mark's mental health or the catastrophic consequences that resulted.

There is no evidence that the deaths of Sarah and John could have been predicted or prevented.

4.2 There were few opportunities to intervene in the life of Mark and for the most part his problems remained hidden.

We now know that he had a troubled early childhood and while a teenager sought help for alcohol use and later for mental health issues.

His lifestyle and the intermittent nature of his drinking made treatment for his alcohol use difficult and unsatisfactory.

He did, however, receive a psychiatric assessment in 2011 which found no evidence of a depressive illness or psychotic symptoms.

In conclusion, the few opportunities for agencies to intervene in the life of Mark were dealt with proportionately given the information at the time.

4.3 It is recorded that Mark sought treatment for depression (low mood) as well as his drinking but that his chaotic lifestyle and the intermittent nature of his drinking made treatment impossible.

4.4 When examined by a psychiatrist after the deaths of Sarah and John, Mark was diagnosed to be suffering from Schizophrenia attended by paranoia, delusions and hallucinations. This report also notes that it is not uncommon for signs and symptoms of such a condition to become clear only in retrospect. Nowhere in the recollections of surviving family members or agency records is there any reference to such a mental state being previously noted in Mark.

4.5 At the outset of this DHR the central question asked was:

> **"Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims?"**

In this case, the very low level of contact between the victims, perpetrator and agencies and the lack of perceived threat made it

impossible to intervene to protect the victims. The police only had limited contact with the perpetrator which was coloured by heavy alcohol use while the GP appears to have responded appropriately to the presentation he saw. Mark had no real history of aggression or violence that would have raised alarm.

In addition, the psychiatric examination of Mark in 2011 found no evidence of a depressive illness or psychotic symptoms.

There appears to have been no indication of Mark's future behaviour or that the deaths of Sarah and John could have been predicted or prevented. In these circumstances it is difficult to identify significant lessons to take forward.

Recommendations

4.7 One issue that has been identified relates to the management of DNAs (did not attend appointments) either at GPs or follow up services. In the case of Mark this was a particular problem as his **intermittent** attempts at self-management of his alcohol problems perhaps led him to believe that he had ongoing control.

Notwithstanding it is recommended that North Tyneside CCG advise all partners to discuss the overall vulnerability of adult patients when considering what follow up actions should be taken in the case of DNAs in any area of the partnership.

Whether such a risk/vulnerability assessment would have raised concerns in the case of Mark is doubtful, such was the lack of any indication of risk in his case. Nevertheless it is believed that in the context of the case real benefit can be gained from multi-agency discussions on general vulnerability in DNA cases where high risk is not always apparent.

Tom Wood
November 2016

SAFER NORTH TYNESIDE

Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones achieved in enacting the recommendation	Target Date	Date of Completion & Outcome
All Partners						
Community Safety Partnership to work with Safeguarding Adults Board to ask Partners to review their policy and procedures when clients default from service provision (Do Not Attend) to ensure that the vulnerability of the patient is taken into consideration when deciding what action (if any) needs to be taken.	Local	Review Policy and Procedures	Safeguarding Adults Joint Case Review Committee	Review of Policy and Procedures completed.	October 2015	